

Letters

Best interests in persistent vegetative state

SIR

While I agree with several points raised in your recent editorial¹ on my paper, Applying best interests to persistent vegetative state - a principled distortion?² I must respond to a number of other issues which you raise. I agree unreservedly with your caveat that both doctors and judges must act within the law. My paper, however, sought to expose that the paradox for the court in the Bland case³ lay in struggling to attain: 1) a morally "right" outcome (withdrawal of life-prolonging treatment (LPT)); while at the same time 2) remaining within the bounds of the current law. As the current law stands it permits allowing patients to die in certain circumstances, whilst prohibiting intentional killing. We should not believe, however, that this state of affairs compels us to accept it as the best we could hope for. Changes to the law may be justified if sufficient moral support exists for making such changes. Although medical ethics, as a discipline, places considerable reliance on moral values, the relationship of law and morality has been traditionally fraught. This latter tension is reflected in the strained semantics of the persistent vegetative state (PVS) decisions. Thus, far from condoning any flouting of the criminal law, I submit that we, as decision makers, need to embrace more honestly the moral content of LPT withdrawal decisions, if decisions are to be clearer and more consistent.

Your editorial suggests that my article implicitly equates "not in" a patient's best interests with "against" best interests. I accept that this is the effect of my approach. However, I adopt this position on the basis that any further distinction regarding best interests is ineffective. While your pro-

posed three categories of "in"; "not in" (presumably neutral); and "against" a patient's best interests are viable regarding "interests" as such, I would argue that the addition of the superlative "best" seeks the optimal action for the patient. This absolutist tone creates an either/or situation, such that an action can only be "in" or "not in" the patient's "best interests". Any further distinction, such as actions which are "not in" or are "against" a patient's best interests, merely represents examples from the same category; namely a non-optimal solution. It is therefore a distinction without difference. Furthermore, while your Smith/Jones example is warranted regarding the patient's interest in other patients' treatment, the LPT decision in PVS obviously relates to the patient personally. Thus, the decision/outcome can never be neutral to that patient's interests, and therefore must fall to one side or other of the "best interests" line.

With regard to my argument that the decisions are founded upon a "delusory objective", (ie that non-treatment is sought rather than the death of the patient), I agree with your suggestion that "...any action is properly described in part by the intentions of the agent...". Certainly, for example, English law's distinction between murder (where death or serious injury is intended) and manslaughter (where such intention is absent) would support your view. However, as a lawyer, I must dispute your conclusion that a patient's death is not "intended" when it is merely "...foreseen as inevitable". Several years of debate in English criminal law have concluded that where an agent foresees death to be the "virtually certain" consequence of his or her actions he or she may be inferred to possess criminal "intention".⁴ Thus, a doctor knowing death to be the virtually certain result of withdrawing LPT from a PVS patient could legally "intend" that death. The House of Lords' denial of

such criminality on the basis that a doctor is under no duty to maintain the patient's life, may (commendably) reflect judicial recognition of such medical action as both morally supportable and ethically sound. However, the complex semantic juggling needed to achieve this moral recognition suggests that medical law is being contorted to bridge the gap between criminal law and modern morality in LPT situations.

Relatedly, your suggested test of a doctor's/judge's true intention (ie his reaction to the patient waking and asking for food) I find unhelpful as, by definition, a PVS patient's consciousness and communication have ceased and the possibility is therefore extremely remote. Contemplating such unlikely events regarding PVS patients is not the answer to establishing doctors' intentions. This is the task of legal and medical professionals and commentators. Open examination and recognition of realistic consequences of decisions is the initial step in providing acceptable solutions to these difficult cases.

With regard to my argument that it is illogical to derive "best interests" from "no interests", I agree entirely with your suggestion that finding the alternative of "no best interests" may be logical where a patient has "no interests". In PVS cases the courts have been compelled to use this approach because the test offered by earlier cases,⁵ namely seeking what is in best interests, seems to offer nothing to weigh in the balance. On this view, "no interests/not in best interests" therefore provides the only logical solution. However, this is premised on the view that only the patient's experiential interests matter. Yet, patients arguably do possess interests beyond the purely experiential.⁶ And, if such interests are deemed to persist beyond entry to PVS,⁷ then merely construing "no interests/not in best interests" is inappropriate, and we must revert to the original construc-

tion of seeking what is in the PVS patient's best interests.

Finally I would emphasise my principal argument which focuses on the need for clear decision making in PVS, LPT decisions. Existing judgments do not - and cannot - deliver this until relevant criminal, civil, medical, ethical and moral issues are openly debated. Undoubtedly all concerned - doctors, family, nursing staff, lawyers and judiciary - seek the best outcome for the patient. However, the appropriate mechanistic tools are needed to allow decisions to be taken with that objective in mind. Recent judicial semantics and reconstructions show that, in England and Scotland at least, courts are not suitably equipped. A broader, empowered judicial function is therefore needed. Open debate of these issues is the essential first step towards meeting the genuine best interests of patients in this tragic, highly personal situation.

References

- 1 Gillon R. Persistent vegetative state, withdrawal of artificial nutrition and hydration, and the patient's "best interests". *Journal of Medical Ethics* 1998;24:75-6.
- 2 Fenwick AJ. Applying best interests to persistent vegetative state - a principled distortion? *Journal of Medical Ethics* 1998;24:86-92.
- 3 Airedale NHS Trust v Bland [1993] 1 All England Law Reports 821.
- 4 R v Hancock and Shankland [1986] Appeal Cases 455; R v Nedrick [1986] 3 All England Law Reports 1.
- 5 F v West Berkshire Health Authority [1989] 2 All England Law Reports 545; Re J (a minor) (wardship: medical treatment) [1990] 3 All England Law Reports 930.
- 6 See for example the notion of "critical interests" in Dworkin R. *Life's dominion - an argument about abortion and euthanasia*. London: Harper Collins, 1993: 199-217.
- 7 See for example the approach to "surviving interests" of Feinberg J. *The moral limits of the criminal law, volume one - harm to others*. New York: Oxford University Press, 1984:83-93.

ANDREA J FENWICK

Department of Private Law, University of Edinburgh, Old College, South Bridge, Edinburgh EH8 9YL

Editor's response

The debate between philosophy, ethics and law is one of the ever more flourishing developments in medical ethics. If Ms Fenwick's assertion is accurate that lawyers and judges have concluded that where an agent foresees death to be the "virtually certain" consequence of his action the agent may be inferred to possess criminal

intention; and if this, as she implies, means the agent *must* be inferred to possess criminal intention; and if "actions" include cessation of action (including withdrawals of trials of treatment); then the law is indeed an ass and required the modification that the House of Lords decision in Bland produced. But if we move away from these legal arguments, there seems nothing contorted or illogical in philosophy, ethics or medical ethics in arguing, as I did, that if a doctor foresees a patient's death as being inevitable as a result of that doctor's action or inaction, this in no way *entails* that the doctor intended that death. That question depends, unsurprisingly, on the doctor's intention! There was no need for Bland's doctors to intend the death of their PVS patient when they ceased providing non-beneficial interventions, even though they foresaw that it was inevitable. Similarly a doctor carrying out cardiopulmonary resuscitation (CPR) need not, and normally does not, intend the death of the patient when he stops the CPR, even though he foresees the inevitable cessation of circulation and consequent death that will follow, if the CPR has failed to evoke a spontaneous heartbeat.

Euthanasia in the Netherlands

SIR

Dr Ryan bases his attack¹ on the validity of the "slippery slope" concept on the 1996 paper of van der Maas *et al*.

A careful examination of the data are not so reassuring. While Dr Ryan is concerned only with non-voluntary euthanasia, there are other data which are also problematic, and their plateau may not yet have been reached. By van der Maas's figures there was a 48% increase in cases of active euthanasia over a five-year period. The authors presented the data in terms of a change from 1.7% to 2.4% and indeed an increase of 0.7% seems minimal. But this increase of 0.7% is a 48% increase and represents over 1,000 additional deaths due to active euthanasia, with no obvious explanation. Whereas in 1990 27-32% of requests for euthanasia were acceded to, this increased to 36-38% in 1995. Some physicians, like myself, interpret the data as an all too ready use of euthanasia to solve difficult patient care problems.

But, in addition, as Dr Ryan himself states: "perhaps the damage was done

in the first ten years that the Dutch allowed euthanasia". Indeed much of current practice is in unequivocal violation of the strict guidelines that the Dutch advocates themselves articulated very clearly when they first proposed their system, and when they assured us that these rules were to be inviolate. These rules were: patient initiation of request; absolute voluntarism; severe suffering; consultation with another physician, and honest and full reporting to the authorities. The widespread violation of these self-imposed restrictions indeed occurred in the first years of the present system.

As one Dutch physician told me in response to the question of how it felt directly to kill a patient: "The first time it was difficult".

Reference

- 1 Ryan CJ. Pulling up the runaway: the effect of new evidence on euthanasia's slippery slope. *Journal of Medical Ethics* 1998;24:341-4.

SHIMON GLICK MD

Jakovovits Center of Jewish Medical Ethics, Ben Gurion University of the Negev, Israel

Greek theories on eugenics

SIR

Professor David Galton has written an interesting article on the Greek theories on eugenics, reviewing the works of Plato and Aristotle.¹ Some more aspects would probably be worthwhile mentioning:

1. Plato's suggestions were not limited to healthy persons reproducing but in preventing the sick and malformed citizens bearing children as well. Such offspring would most probably be as wretched as their parents² and should not be reared.³
2. Beyond infanticide of the unwanted progeny, Plato's suggestions included abortion⁴ and transmission to the "other city".⁵ The latter proposal has led scholars to deny that infanticide was really meant by Plato and probably this passage and not the mentioned one from Herodotus¹ led the late Professor Francis Galton to make the comment about the formation of colonies.
3. Morbid genetic material would not only have been undesired by the state but would inhibit individual evolution as well⁶ providing a bad quality of life.⁷ Although it sounds